Commonwealth of Massachusetts
Group Insurance Commission

# Initial Insurance Enrollment Form
## Non-Medicare Retirees/Survivors
# SHERIFFS/TRANSPORTATION

**Return completed form to the GIC Coordinator at your Benefits Office. Do not return to the GIC**

01 ☐

| Insured's GIC-ID (usually Soc. Sec. #) | Sex: Male ☐ Female ☐ | Date of Birth | Dept. ID # or Agency/Division # | Check one: ☐ Retiree ☐ Survivor / Date of retirement ____/____/____ | For Agency Use Only |
|---|---|---|---|---|---|
| — — | | / / | / | | |
| Name - Last | First | | MI | | |
| Address ☐ This is a new address | City | State | Zip Code | | |
| Retiree/Survivor from (check one): ☐ MBTA ☐ Tobin Bridge ☐ Mass Turnpike ☐ Sheriffs (fill in name):_____ | | | Home Phone ( ) | | |

02 ☐ **BASIC LIFE AND HEALTH COVERAGE** **Effective Date: / 01 /**

New Enrollment ☐ Decline Coverage ☐ Cancel Coverage ☐

☐ **Basic Life and Health** (Select one of the health plans below and individual or family coverage) ☐ **Basic Life Only** Note: Survivors not eligible for Basic Life

**Health Plan**

- ☐ Fallon Direct
- ☐ Fallon Select
- ☐ Harvard Pilgrim Independence
- ☐ Harvard Pilgrim Primary Choice
- ☐ Health New England
- ☐ NHP Care – Neighborhood Health Plan (HMO app required)
- ☐ Tufts Health Plan Navigator
- ☐ Tufts Health Plan Spirit
- ☐ UniCare State Indemnity/Basic CIC: ☐ Yes ☐ No
- ☐ UniCare/Community Choice
- ☐ UniCare/PLUS

☐ Individual
☐ Family

**SPOUSE/DEPENDENT INFORMATION**

List below all family members, including your spouse or former spouse (if eligible), who will be covered under your health plan. Attach a seperate sheet if additional space is required. Please provide all Social Security Numbers and exact dates of birth for each dependent. Coverage for children ends at age 19; to continue their coverage you must complete and return to the GIC a Dependent Age 19 and Over Application for Coverage. **Important:** The Group Insurance Commission requires you to provide a copy of a marriage certificate, birth certificate, certificate of appointment as legal guardian, legal separation agreement, and divorce decree for each person you list as a dependent.

| Last Name | First | Middle | Relationship | Date of Birth | Sex | Social Security Number |
|---|---|---|---|---|---|---|
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| | | | | | | |

Effective date: _____

## SPOUSE INFORMATION

Is your spouse employed? ☐ Yes ☐ No Name of employer _____ Address of employer _____

Is your spouse covered under his or her employer's group health insurance plan? ☐ Yes ☐ No Name of insurance company _____

Policy/Certificate Number_____ Address of insurance company_____

Are you and/or your children covered under your spouse's group health insurance plan? You: ☐ Yes ☐ No Children: ☐ Yes ☐ No

Is your spouse enrolled in Medicare? ☐ Yes ☐ No If yes, Medicare claim number_____

## FORMER SPOUSE INFORMATION

Name _____ Social Security Number _____ Date of Birth _____ Date of Divorce _____

Last First Middle

Address _____

Street City State Zip Code

Is your former spouse employed? ☐ Yes ☐ No Name of employer _____

Is your former spouse covered under his or her employer's group health insurance plan? ☐ Yes ☐ No

SIGNATURE REQUIRED

**Deduction Authorization**: I authorize my employer, or direct my pension authority, to deduct from my payroll or pension check the amount required for the coverage I have selected.
**Survivors:** I am a surviving spouse and certify that I have not remarried and understand that if I do remarry I am no longer eligible for GIC coverage.

If you are enrolling in an HMO that requires a separate application, be sure to file the application with the plan.

x _____ x _____

Signature of Applicant Date Signature of Authorized Official Date

| FOR GIC USE ONLY: | Entered | Verified | Political Subdivision |
|---|---|---|---|
| | | | |